The Boulder Acupuncture Clinic **Patty Dautremont Johns,L.Ac.**

Confidential Health History

Dear Patient: This information is considered confidential. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name:_____

Spouse or Parent:_____

Date of Birth:_____Age:_____Social Security #:_____

Cell Phone_____Home Phone_____ Work Phone _____

Address:_____

City/State:_____ ZIP:_____

Email Address:_____

Occupation:_____ Employer:_____

Emergency Contact:_____ Phone_____

How did you hear about us?_____

Physician:_____Physician's Phone:_____

Last seen by physician:_____

Have you had acupuncture before? _____ Have you taken Chinese Herbs before?_____

CHIEF COMPLAINT: (Please describe the principal health problem)

_____

_____

_____

Onset _____ Recurrence _____

Describe what caused it or how it started: _____

_____

_____

Have you Ever had this condition or similar conditions before: _____

Have you received any other care for your Chief Complaint? _____

If yes who? _____

When? _____

What was the diagnosis? _____

What was the treatment? _____

Has the condition gotten ___Better ___Worse ___About the same

What makes it better? _____

What makes it worse? _____

PAST HISTORY

List of Major Surgeries, Illnesses, Diseases and Accidents (include dates) _____

_____

_____

_____

PERSONAL HISTORY:

____Polio
____Thyroid disorders
____Jaundice
____Nervous disorders
____Pneumonia
____Cancer
____Heart trouble
____Kidney disease
____Liver disease
____Eye disease
____Spinal problems
____Diabetes
____TB
____Glaucoma
____Gonorrhea
____Multiple Scleroses
____Chronic Fatigue
____Epilepsy
____Ulcers
____Arthritis
____ Mental Disorders
____ High blood pressure
____ Low blood pressure
____ Allergies
____ Asthma
____ Sinus Problems
____ Alcohol Addiction
____ Drug Addiction
___ Obesity
___ Emotional Disorders

Blood type _____

Other _____

ALLERGIES: (drugs, chemicals, food, animals, seasonal, ect.) _____

_____

CONTAGIOUS DISEASES: Check if you have ever had one of the following:

___HIV+ ___AIDS ___Hepatitis __ Venereal Disease ___ Herpes ___Other_____

How often do you take Antibiotics?_____

Please List: Medication, Supplements and Herbs taken within the last month (include prescription, over-the-counter drugs, nutritional supplements, herbs, etc.)

MEDICATION	SUPPLEMENTS	AMOUNT	FREQUENCY	FOR WHAT CONDITION	DATE STARTED

FAMILY MEDICAL HISTORY:

____Cancer
____Heart trouble
____Kidney disease
____Liver disease
____Eye disease
____Spinal problems
____Diabetes
____TB
Glaucoma
____Gonorrhea
____Multiple Scleroses
____Chronic Fatigue
____Epilepsy
____Ulcers
____Arthritis
___ Obesity
____ Mental Disorders
____ High blood pressure
____ Low blood pressure
____ Allergies
____ Asthma
____ Sinus Problems
____ Drug Addiction

Other _____

Age and general health of parents: Mother_____Father_____

HABITS:

____Cigarettes
____Coffee
____Black tea
____Soft Drinks
____Alcohol
____Sugar
____ Salt
____ Recreational drugs
____ Stress

EXERCISE:

____Never ____ Little ____Moderate ____Heavy

Type of exercise:_____

EMOTIONALLY:

____Happy
____Angry
____Depression
____Easily irritable
____Cry easily
____Stressed
___ Difficulty making decisions
___ Hurry to do things
___ Restless

DIET (Typical Foods):

____Beef
____Pork
____Poultry
____Fish
____Eggs
____Bread
____Milk
____Butter
____Cheese
____Margarine
____Ice Cream
____Vegetables
____Grains
____Fried foods
____ Sweets
____ Salads
____ Tofu
____ Yogurt
____ Health Foods
____ Hot spicy food

Other _____

Cravings _____

Number of meals per day? _____Do you eat at regular hours? _____

What type of beverages do you drink?_____
Has you diet been different in the past?_____

Please give a brief description of your diet:

Early Morning/ Breakfast: _____

Mid morning snacks:_____

Lunch: _____

Dinner: _____

Evening snacks:_____

APPETITE:

____Up & down
____Poor
____Good
____Hungry a lot
____ Loss of taste

WEIGHT:

____Normal
____Underweight
____Overweight
____Recent gain
____ Recent loss

ENERGY:

____Up & down
____Low
____Normal
____Excess
____ Low after eating
____ Tired in the afternoon

DIGESTION:

____Gas
____Indigestion
____Heartburn
____Gallstones
____Bloating
____Bad breath
___ Weight problems
___ Belch or burp
___ Bitter taste in mouth
___ Nervous stomach
___ Nausea/vomiting
___ Stomach noises
___ Abdominal pain or cramps
___ Difficult digesting fatty foods
___ Difficult digesting oily foods
___ Full feeling or distention
___ Normal

Other_____

BOWELS:

____Loose stool
____Diarrhea
____Constipation
____Colon problems
____Black stool
____Pain or cramps
____Blood in stool
____Hemorrhoids
____Anus itch
____Burning anus
____Hard stool
____Use laxatives
____ Undigested food in stool
____ Stool with bad smell
____ Mucous in stool
____ Small amount of stool
____ Intestinal worms
____ Normal

Other _____

URINATION:

____Nighttime
____Profuse
____Scanty
____Burning
____Blood
____Pus
____Painful
____Bladder infections
____Incontinence
____Strong smell
____ Not normal color
____ Urgency
____ Kidney stones
____ Cloudy
____ Normal

Other _____

THIRST:

____Less than normal
____Thirsty but do not drink
____Excessive
____Prefer cold drinks
____ Prefer hot drinks
____ Normal

BODY TEMPERATURE:

____Warm natured
____Cold natured
____Flushed face
____Warm palms
____Warm soles
____Cold hands & feet
____Warmer late afternoon and night
____Alternate chills and fever
____Normal

Other _____

PERSPIRATION:

____Very little
____Profuse
____Without exertion
____Easily
____Palms
____Feet
____ Night Sweats
____ Bad smell
____ Normal

Other _____

SLEEP:

____Difficulty falling asleep
____Awake easily
____Difficulty going back to sleep
____ Lots of dreams
____ Nightmares
____ Restless
____ Tired when get up
____ Sleep too much
____ Normal

Other _____

HEADACHES – DIZZINESS:

____Headaches ___ Vertigo ____Poor balance
____Dizziness ___ Motion sickness ____Poor memory
____Faint easily ___ Migraines ____Bend down and stand up and get dizzy

Other_____

SKIN:

____Dry ____Hives ____ Clammy
____Oily ____Pimples ____ Bruise easily
____Rashes ____Moles ____ Cuts heal slowly
____Itching ____Warts ____ Yellow skin
____Eczema ____Boils ____ Normal
____Ulcers ____Body odor

Other_____

HAIR:

____Dry ____Dandruff ____ Early gray
____Oily ____Falling out ____ Normal

Other _____

NAILS:

____Soft ____Spots ____ Grow slowly
____Break easily ____Pale ____ Grow fast
____Ridges & lines ____Purple ____ Normal

Other _____

EARS:

____Poor hearing ____ Ringing (high pitch) ____ Discharges
____Ear aches ____Ringing (low pitch) ____ Normal

Other _____

EYES:

____Inflammation ____ Twitch ___ Spots or lines in vision
____Yellow sclera ____ Strain ___ Pale under eyelids
____Failing vision ____ Tear easily ___ Poor night vision
____Sty history ____ Red ___ Sensitive to light
____Blurry vision ____ Dry ___ Color blindness
____Cataracts ____ Itch ___ Eyelids swollen
____Glaucoma ____ Pain ___ Normal
____Blink ____ Wear glasses or contacts

Other_____

NOSE:

____Stuffy nose ___ Bleeding ___ Environmental sensitivity
____Mucous ___ Rhinitis ___ Blow nose a lot
____Sinusitis ___ Sneeze a lot ___ Normal
____Hay fever ___ Loss of smell

Other_____

MOUTH & THROAT:

____Frequent sore throats
____Difficulty swallowing
____Thyroid problems
____Swollen glands
____Feel lump in throat
____Gum problems
___ Sores in mouth/tongue
___ Dry
___ TMJ
___ Hiccups
___ Grind teeth
___ Teeth problems
____ Hoarseness
____ Frequent colds
____ Dry cracked lips
____ Drool a lot
____ Normal

Other_____

RESPIRATORY:

____Chest pain
____Asthma
____Dry cough
____Sigh a lot
____Bronchitis
____Difficulty inhaling
____Difficulty exhaling
____Cough a lot
____Tightness in chest
____Cough with blood
___ Cough with phlegm
___ Difficulty breathing when lying down
___ Shortness of breath
___ Normal

Other_____

CARDIOVASCULAR – CIRCULATION:

____Murmur
____Palpitations
____Bleed easily
____High cholesterol
____Ankle swelling
____Facial swelling
____Hand swelling
___ Varicose veins
___ Chest pain
___ Bruise easily
___ History of anemia
___ Slow beating of heart
___ Irregular heart beat
___ Diagnosed heart problems
___ Low blood pressure
___ High blood pressure
___ Numbness in extremities
___ Broken blood vessels
___ Purple palms and fingers
___ Normal

Other _____

ANY OHER PROBLEMS YOU WOULD LIKE TO DISCUSS: _____

_____

*****PLEASE DO NOT BRUSH YOUR TONGUE BEFORE YOUR TREATEMENT*****

FOR MALES ONLY: (Please check and explain if applicable)

____Reduced sex drive _____

____Premature ejaculation _____

____Seminal emission _____

____Impotence_____

____Discharges _____

____Genital pain _____

____Prostate problems _____

____Pain or burning upon urination _____

____Dribble urine _____

If you are male, congratulation you have just completed this form.

If you are female please continue.

Are you or might you be pregnant? _____YES _____NO _____MAYBE

If yes approximate date of conception? _____

Are you experiencing reduced sex drives? _____YES _____NO

Other difficulties? _____

Do you have regular PAP Test? _____YES __NO Date of last PAP_____

Do you have regular breast exams? _____YES _____NO

Do you have facial or excessive body hair? _____YES _____NO

What method of birth control do you now use? _____

What method of birth control have you used in the past? _____

MENSTRUAL CYCLE: (Please check and explain as applicable)

Age started_____ Days of flow _____ Age stopped _____

How many days from the beginning of your period to the start of you next period? _____

Date of your last period_____

MENSTRUAL SYMPTOMS:

____Irregular ___Abdominal bloating ___Cramps ___Back Pain ___Water retention

___Dark color flow ____Painful or tender breasts ___Heavy flow ___Scanty flow ___Clotting

____Breast lumps ___Spotting between periods ____Sigh a lot ___Lump feeling in throat

_____Constipation ___ Diarrhea ___Tightness in chest ___Hormonal problems

_____Emotional changes Other _____

_____

VAGINAL DISCHARGES:

____Yellow ___White ___Clear ___Thick ___Thin ___Bad odor Other_____

OVULATION SYMPTOMS: _____

MENOPAUSE SYMPTOMS: _____

PREGNANCY OR CHILDBIRTH COMPLICATIONS:

_____

_____

GYNECOLOGICAL HISTORY AND OPERATIONS:

____Ovaries_____

____Uterus_____

____Fallopian tubes_____

____Vagina_____

____Breasts_____

____Other_____